

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT#1 WESTMINSTER MD					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER MD				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEADOWVIEW NURSING HOME					d. STREET ADDRESS ROUTE # 2				
3. NAME OF DECEASED (Type or print) First Middle Last MARY MARGARET BANKERT					4. DATE OF DEATH Month Day Year JULY 6 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 18 1906		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CARROLL MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME SAMUEL HANN					14. MOTHER'S MAIDEN NAME SARAH CATHERINE MYERS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 213-09-5445				
17. INFORMANT MRS RUSSELL CRAWMER					Address ROUTE # 7 WESTMINSTER MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA (TERMINAL) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ARTEROSCLEROTIC CARDIOVASCULAR D DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 4 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from OCT 1957 , to JULY 1967 , that (I) (we) last saw the deceased alive on 7/6 1967 , and that death occurred at 4:45 M, from the causes and on the date stated above.									
22a. SIGNATURE Daniel I. Welliver M.D.					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER					22d. ADDRESS 19 BRIDGE ROAD WESTMINSTER MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/8/67		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery			23d. LOCATION (City, town or county) (State) Silver Run, Carroll Co. Md.	
24. FUNERAL DIRECTOR Richard A. Little					ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR JUL 10 1967 25b. REGISTRAR'S SIGNATURE James J. [Signature]		

CARROLL

W. E. CARROLL

HOUSE WIFE

HOUSE WIFE

SAMUEL HALL

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 1yr. 10mos. 12dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JUSTICE Middle (MNN) Last BREMER		4. DATE OF DEATH Month JULY Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY building	9. AGE (In years last birthday) 91 yrs.
11. BIRTHPLACE (County & State, or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bremer		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 215-12-1450	17. INFORMANT Records, Springfield State Hospital Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left cerebral softening DUE TO (b) Cerebral thrombosis DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Weeks Weeks Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-1-65 to 7-13-67 , 19____, that (I) (we) last saw the deceased alive on 7-13-67 19____, and that death occurred at 8:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo.</i>		22b. DATE SIGNED 7-14-67	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-15-67	23c. NAME OF CEMETERY OR CREMATORY New Freedom	23d. LOCATION (City or Town) (County) (State) Sykesville, Md.
24. FUNERAL DIRECTOR <i>Harry Haight</i>		25a. REC'D BY REGISTRAR JUL 19 1967 DATE	
ADDRESS <i>Sykesville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09382											
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY in lb <u>12</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Golden Age Sweet Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>50-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>304 EVESHAM AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>John Harrison Burgett</u> First <u>John</u> Middle <u>Harrison</u> Last <u>BURGET</u>						4. DATE OF DEATH <u>July 8 1967</u> Month <u>July</u> Day <u>8</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 19, 1894</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SHAHOKIN PA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM BURGETT</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE BURGETT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) <u>WWI ARMY</u>				16. SOCIAL SECURITY NO. <u>198-03-8591</u>		17. INFORMANT Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Overload</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral act. 1966</u> (a), stating the underlying cause last. (c) <u>Gen. Arthur Seligson</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 3, 1967</u> to <u>July 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1967</u> , and that death occurred at <u>304 Evesham Ave.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>M N MASTIN</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>M N MASTIN</u>						22d. ADDRESS <u>Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY MEM.</u>				23d. LOCATION (City, town or county) (State) <u>COCKEYSVILLE MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns</u> ADDRESS <u>Ston Md.</u>						25a. REC'D BY REGISTRAR <u>JUL 14 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

135

STATE OF NEW YORK

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09383

CERTIFICATE OF DEATH

09383

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7yrs. 9mos. 5dys.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 2905 Lindell St.			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle LUNDAY Last CARLTON				4. DATE OF DEATH Month JULY Day 19 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-12-04	
9. AGE (In years last birthday) 63		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (County & State, or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Carlton				14. MOTHER'S MAIDEN NAME Martha (last name unk.)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 579-09-4091		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO (b) Heart failure DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(p) Psychotic depressive reaction. CBS with alcohol intox.,							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-13-59 , 19 7-19-67 , 19 7-19-67 , that (I) (we) last saw the deceased alive on 7-19-67 , 19 , and that death occurred at 1:35 PM , from causes and on the date stated above.							
22a. SIGNATURE Octavio A. Ruiz				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-19-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/22/67		23c. NAME OF CEMETERY OR CREMATORY UNION		23d. LOCATION (City or Town) (County) (State) BURTONSVILLE MD	
24. FUNERAL DIRECTOR W.W. Chambers Co. Inc.				25a. REC'D BY REGISTRAR W.W. Washington		25b. REGISTRAR'S SIGNATURE JUL 21 1967	

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04520

09384

CERTIFICATE OF DEATH

09384

1. PLACE OF DEATH a. COUNTY Ga. rroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 38y.1m.3d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3544 Cedar Avenue	
3. NAME OF DECEASED (Type or print) Sadie		4. DATE OF DEATH Month July Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-01
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Glorioso		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-7416	
17. INFORMANT Records		Address Springfield State Hospital, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mediastie lung disease DUE TO (b) Adenocarcinoma of gallbladder DUE TO (c) 1551 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Months Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-2-29 , 19 29 , to July 14 , 19 67 , that (I) (we) last saw the deceased alive on July 14 , 19 67 , and that death occurred at 6:50 a.m. from causes and on the date stated above.			
22a. SIGNATURE Paul G. Insor, M.D.		22b. DATE SIGNED July 15, 1967	
22c. PHYSICIAN'S NAME (Type) Paul G. Insor, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7-26-67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) BALTO. Md.
24. FUNERAL DIRECTOR Harry Wm Haight		25a. REC'D BY REGISTRAR DATE JUL 28 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			

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1684

11

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09385

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 15 Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rd. 4 Westminster		d. STREET ADDRESS Rd. 4 Westminster	
3. NAME OF DECEASED (Type or print) PAULA First Middle Last		4. DATE OF DEATH July 29, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1938
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Romania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Carl Gross		14. MOTHER'S MAIDEN NAME Maria Velixer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Corleto Funeral Home, Wilmington, Delaware		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 981X IMMEDIATE CAUSE (a) Multiple shotgun wounds DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject was shot with shotgun in lt. side neck	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ? ? 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westminster Carroll Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED July 30, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		23. NAME OF CEMETERY OR CREMATORY Silver Brook	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8 2 67	
24. FUNERAL DIRECTOR Mc Cully		25. ADDRESS 130 E. Fort Ave	
25a. REC'D BY REGISTRAR AUG 2 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

MEDICAL CERTIFICATION

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09386

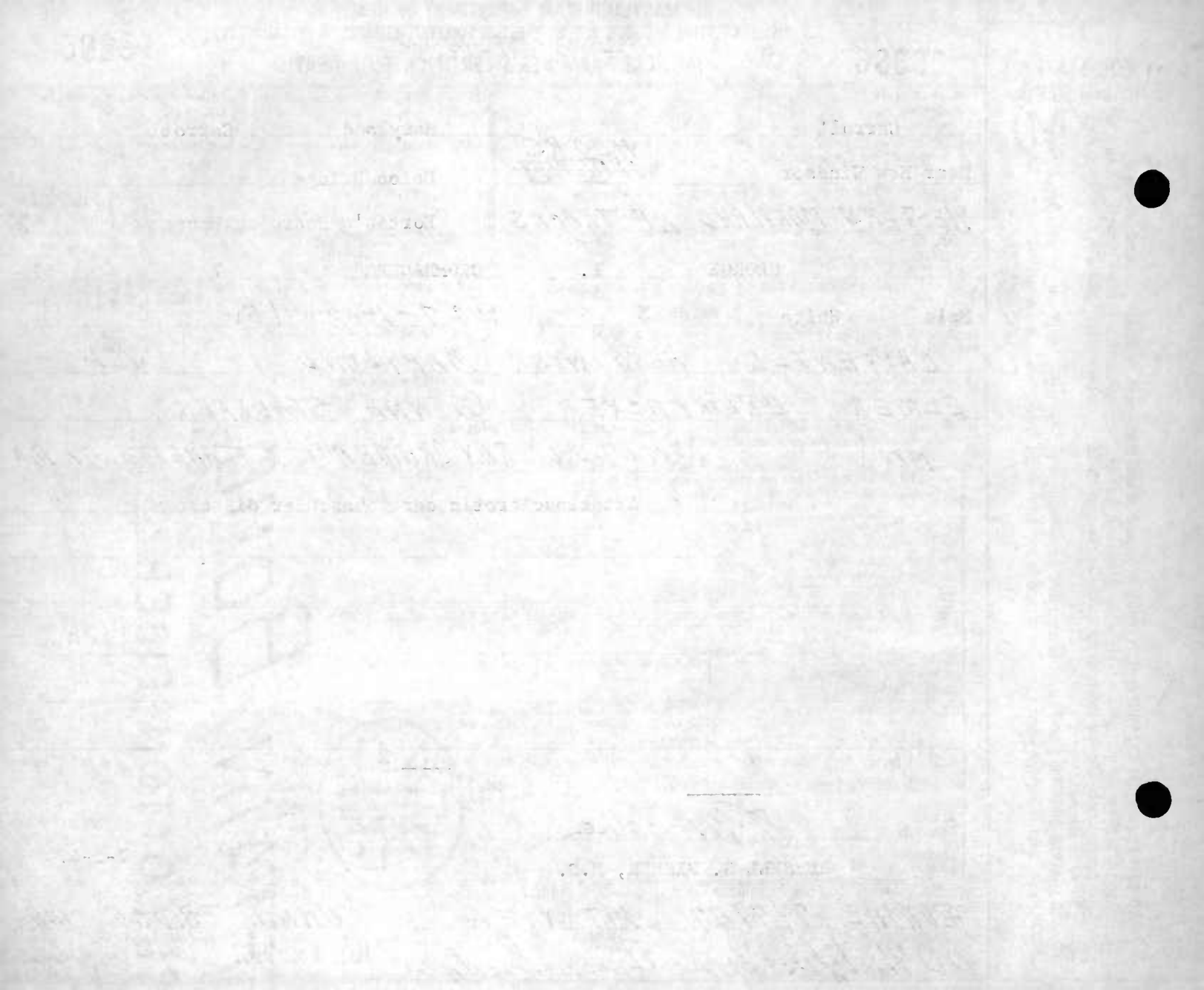
09386

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near New Windsor			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND RR TRACKS			d. STREET ADDRESS Horton's Boarding House		
3. NAME OF DECEASED (Type or print) GEORGE E. CRUMBACKER			4. DATE OF DEATH Month 7 Day 4 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 7 - 1902		9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY WOOD WORK		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME ELMER CRUMBACKER		
14. MOTHER'S MAIDEN NAME GLENNA STAUFFER			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219-67-2045			17. INFORMANT RAY CRUMBACKER TANEYTOWN MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.			22. DATE SIGNED 7-5-67		
EXAMINER'S NAME (Type)			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/7/67		23c. NAME OF CEMETERY OR CREMATORY MT VIEW	
23d. LOCATION (City or Town) _____ (County) _____ (State) _____		23e. REGISTRAR'S SIGNATURE J. Charles Jones			
24. FUNERAL DIRECTOR DD Hartzler & Sons		ADDRESS Union Bridge		25a. REC'D BY REGISTRAR JUL 10 1967	



09387

CERTIFICATE OF DEATH

09387

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 yrs./5 mos.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle William Last DENLEY		4. DATE OF DEATH Month July Day 8 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1895	9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York	
13. FATHER'S NAME Edward Denley - dec.		14. MOTHER'S MAIDEN NAME Elizabeth Mesnick - dec.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.I & II 219-01-1330		17. INFORMANT Address Springfield State Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1-47X Metastatic squamous cell carcinoma rt. side of neck. DUE TO (b) Carcinoma of the hypopharynx. DUE TO (c) mos.					INTERVAL BETWEEN ONSET AND DEATH mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with alcoholic intoxication with psychotic reaction.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that the (this hospital) attended the deceased from 2-8-64 , 19 64 to 7-8- , 19 67 , that (I) (we) last saw the deceased alive on 7-8-67 , 19 67 , and that death occurred at 6:15 p.m. from causes and on the date stated above.					
22a. SIGNATURE Jose I. Alsina		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-8-67	
22c. PHYSICIAN'S NAME (Type) Jose I. Alsina, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/12/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City or Town) (County) (State) Taylor Ave, Md					
24. FUNERAL DIRECTOR Stinson Funeral Home		ADDRESS 3818 Roland Ave		25a. REC'D BY REGISTRAR JUL 11 1967	
				25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed on 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL CO. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 50 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 50 LIBERTY ST.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 50 LIBERTY ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARTIN WARNER DIFFENDAL		4. DATE OF DEATH Month Day Year JULY 25 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 16, 1904
9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK, APPAREL STORE		10b. KIND OF BUSINESS OR INDUSTRY WESTMINSTER MD	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME J. GLOYD DIFFENDAL		14. MOTHER'S MAIDEN NAME JENNIE L. HANDLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWII		16. SOCIAL SECURITY NO. 217-22-8786	
17. INFORMANT Miss Glessie R. Handley, Westminster Md. Address Anchor St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Codine carcinoma of sigmoid, 1533 DUE TO (b) involving small bowel and bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) March 1967		INTERVAL BETWEEN ONSET AND DEATH March 1967	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Operative + biopsy June 1967)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 15, 1967 , to July 25, 1967 , that (I) (we) last saw the deceased alive on July 25, 1967 , and that death occurred at 12 noon M, from the causes and on the date stated above.			
22a. SIGNATURE C. L. Billingslea M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. L. Billingslea, M.D.		22d. ADDRESS Westminster, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/28/67	
23c. NAME OF CEMETERY OR CREMATORY Kinder Cemetery		23d. LOCATION (City, town or county) (State) Rural Westminster Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR JUL 27 1967 25b. REGISTRAR'S SIGNATURE Charles Jones	

09383

CERTIFICATE OF DEATH

09383

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>6 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll's General Hospital</u>				d. STREET ADDRESS <u>Penn. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael</u> ^{first} <u>Patrick</u> ^{Middle} <u>Drumheller</u> ^{Last}				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry J. Drumheller</u>				14. MOTHER'S MAIDEN NAME <u>Deane Kerner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Henry J. Drumheller</u> Address <u>111 1/2 Penn. Westminster, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity 1'-11"</u> 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>no</u> DUE TO (c) <u>no</u>							INTERVAL BETWEEN ONSET AND DEATH <u>no</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Placental Separation of Placenta</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-24</u> , 19 <u>67</u> , to <u>7-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-24</u> , 19 <u>67</u> , and that death occurred at <u>4:10 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Paul M. Leary</u>				22b. DATE SIGNED <u>7/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Paul M. Leary</u>	
22d. ADDRESS <u>Westminster, Md.</u>				22e. ADDRESS <u>Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md.</u>				25a. RECEIVED BY REGISTRAR DATE <u>JUL 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Myers</u>	

1924

CERTIFICATE OF DEATH

1924

Name of Deceased		John J. Campbell	
Age		45	
Sex		Male	
Race		White	
Date of Death		July 24, 1924	
Place of Death		St. Joseph's Hospital	
Cause of Death		Heart Disease	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Minister		[Signature]	
Signature of Coroner		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Cemetery		[Signature]	
Signature of Church		[Signature]	
Signature of Family		[Signature]	
Signature of Friends		[Signature]	
Signature of Neighbors		[Signature]	
Signature of Community		[Signature]	
Signature of State		[Signature]	
Signature of Nation		[Signature]	



09330

CERTIFICATE OF DEATH

09330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 9mos. 2dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle G. Last ELLERBROCK		4. DATE OF DEATH Month JULY Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-1891
9. AGE (In years last birthday) 75 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Kansas	
13. FATHER'S NAME Larry A. Gray		14. MOTHER'S MAIDEN NAME Alice Foster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) No		16. SOCIAL SECURITY NO. 212-07-9343A	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung abscess and bronchopneumonia Days or weeks 6000 DUE TO (b) Possible bacteremia Weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Suppurative nephritis Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 10-18-66 , to 7-20-67 , 19__, that (2) (we) last saw the deceased alive on 7-20-67 , 19__, and that death occurred at 5:20 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Antonius Glahn</i> M.D.		22b. DATE SIGNED 7-21-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/24/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR DATE JUL 21 1967	
ADDRESS 4905 York Road Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>	

CERTIFICATE OF ANALYSIS

1918

ANALYST

DATE

PLACE

NAME

QUANTITY

REMARKS

TESTED

BY

RESULT

AND

CONCLUSION

NOTE

REMARKS

SIGNATURE

ANALYST

DATE

ANALYST'S NAME

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ANALYST'S NAME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09391

CERTIFICATE OF DEATH

09391

1. PLACE OF DEATH o. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>		d. STREET ADDRESS <u>20 Penna. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET LAUVENIA ENGLAR</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary, insurance office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New Windsor, Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Wesley Michael</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-03-4347</u>	
17. INFORMANT <u>Miss Helen C. Michael</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1967</u> , to <u>July 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1967</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u> M.D.		22b. DATE SIGNED <u>7/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>Sancho St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/28/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Uniontown Lutheran</u>		23d. LOCATION (City or Town) (County) (State) <u>Uniontown Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR <u>E. E. Myers, Jr.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Yunge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUL 27 1967</u>	

5297

09392

CERTIFICATE OF DEATH

09392

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg		c. LENGTH OF STAY IN lb 1 week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brookfield Manor Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown	
3. NAME OF DECEASED (Type or print) First Emma Middle Jane Last Formwalt		4. DATE OF DEATH Month July Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1866
9. AGE (In years lost birthday) yrs. 101		10. BIRTHPLACE (County & State, or foreign country) Carroll Co, Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Bankerd		14. MOTHER'S MAIDEN NAME Mary Elizabeth Heis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mr. Harry H. Haines, Uniontown, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic C.V.D. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/1/40 , 19__, to 7/3/67 , 19__, that (I) (we) last saw the deceased alive on 7/2/67 , 19__, and that death occurred at 7:15 p M, from causes on and on the date stated above.			
22a. SIGNATURE M. E. Robertson		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) M. E. Robertson		22d. ADDRESS New Windsor Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	23d. LOCATION (City or Town) (County) (State) Uniontown, Carroll, Maryland
24. FUNERAL DIRECTOR John H. Skiles C.O. Fuss & Son		25. REC'D BY REGISTRAR JUL 7 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5400

[illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

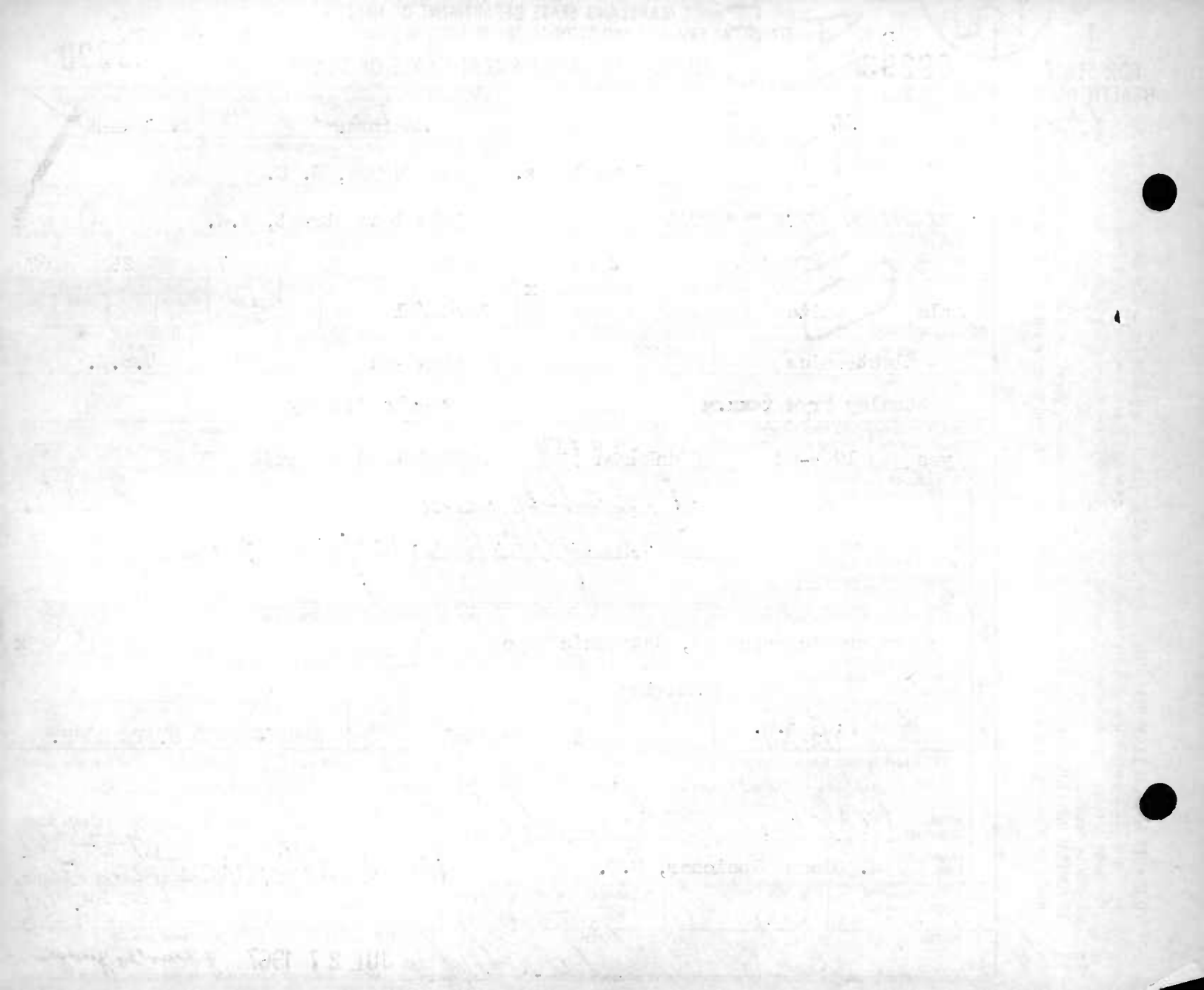
VR A15ME (5)
6M 1/66

09393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09393

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 1 mo 10 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL				d. STREET ADDRESS 3420 16th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle JOHN Last FRYE				4. DATE OF DEATH Month 7 Day 25 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/06/41		9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months 25 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronics		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley Frye (deceased)				14. MOTHER'S MAIDEN NAME Angela Anthony			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1959-62		16. SOCIAL SECURITY NO. 262 62 9920		17. INFORMANT SPRINGFIELD HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Strangulation By Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, Catatonic type							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:05 a.m. p.m. 7/25/67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) SPRINGFIELD STATE HOSP.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF July 28, 1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		23d. LOCATION (City or Town) (County) (State) BLADENSBURG - MARYLAND	
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		25a. REC'D BY REGISTRAR JUL 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

09394

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb lyr.9dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUISE Middle MAE Last GAREY		4. DATE OF DEATH Month JULY Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-8-13
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Sourbrine		14. MOTHER'S MAIDEN NAME Minnie Ruby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-7018	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute coronary artery occlusion DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-13-66 , 19__ to 7-20-67 , 19__, that (I) (we) last saw the deceased alive on 7-20-67 , 19__, and that death occurred at 2:00 PM from causes on and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens	23d. LOCATION (City or Town) (County) (State) La Vale, Md. Cash Valley Rd
24. FUNERAL DIRECTOR Mr. Harvey Zeigler Hyndman		25a. REC'D BY REGISTRAR JUL 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09395

CERTIFICATE OF DEATH

09395

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 3y. 9m. 12d.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1671 Argonne Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Brockenbrough Last Garland		4. DATE OF DEATH Month 7 Day 19 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/85
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer - Retired	
10b. KIND OF BUSINESS OR INDUSTRY Hutzler Co.		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Moore Brockenbrough Garland	
14. MOTHER'S MAIDEN NAME Sallie Frances Brent		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 215-10-6001		17. INFORMANT Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis without qualifying phrase.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/7/ , 19 63 , to 7/19/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/19/ , 19 67 , and that death occurred at 6:45 a.m. from causes and on the date stated above.		22a. SIGNATURE Sherrill C. Cheeks M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22b. DATE SIGNED 7/19/67		22c. PHYSICIAN'S NAME (Type) Sherrill C. Cheeks, M. D.	
22d. ADDRESS Springfield State Hospital Sykesville, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 7/21/1967		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co., Md.		24. FUNERAL DIRECTOR H.W. Jenkins & Spns Co. 4905 York Rd. Balto. 12, Md.	
25a. REC'D BY REGISTRAR JUL 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

0232

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09396		09396	
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN b 20 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7 RIDGE ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 7 RIDGE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle STONER Last GEIMAN		4. DATE OF DEATH Month JULY Day 15 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 16 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE SALES		10b. KIND OF BUSINESS OR INDUSTRY RETAIL	
11. BIRTHPLACE (County & State, or foreign country) CARROLL MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID ROYER GEIMAN		14. MOTHER'S MAIDEN NAME IDA SUMMERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-32 1886	
17. INFORMANT STONER GEIMAN JR. 77 W MAIN ST WESTMINSTER MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE - 5 YEARS DUE TO (c) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 1956 to JULY 1967 , that (I) (we) last saw the deceased alive on JULY 15 1967 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Daniel J. Welliver		22b. DATE SIGNED 7-15-67	
22c. PHYSICIAN'S NAME (Type) DANIEL J. WELLIVER		22d. ADDRESS WESTMINSTER MD	
23a. BURIAL (CREMATION REMOVAL) (Specify) Cremation	23b. DATE THEREOF 7/15/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City, town or county) (State) Bladensburg Md.
24. FUNERAL DIRECTOR J. E. Myers, Jr. Westminster, Md.		25a. REC'D BY REGISTRAR J. E. Myers, Jr. DATE JUL 17 1967	
25b. REGISTRAR'S SIGNATURE J. E. Myers, Jr.			

CERTIFICATE OF DEATH

09397

09397

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>69 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RD #6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SMALLWOOD</u>				d. STREET ADDRESS <u>SMALLWOOD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARION BROWN GORE</u>				4. DATE OF DEATH Month Day Year <u>JULY 2 1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899 FEB 12 1898</u>	
				9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTOMOBILE SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HILLARY B. GORE</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE E. HARDEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-28-1111</u>		17. INFORMANT <u>MRS. MARION B. GORE</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>July 2, 1967</u> that (I) (we) last saw the deceased alive on <u>June 30, 1967</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>8 Archer St. Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER MD.</u>	
24. FUNERAL DIRECTOR <u>J. S. Mayne, Jr., Westminster, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1932

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1932

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WILLIAM W. CHURCH

09398

CERTIFICATE OF DEATH

09398

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		d. STREET ADDRESS 405 Collier Avenue	
3. NAME OF DECEASED (Type or print) GUSS, SAMUEL (NMN)		4. DATE OF DEATH 7 25 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05/??/1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years lost birthday) yrs. 77
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Naturalized	
13. FATHER'S NAME Hiller Guss (dec)		14. MOTHER'S MAIDEN NAME Eva ??	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 031-03-2366-4	
17. INFORMANT SPRINGFIELD HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. H201 (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain disease with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/10/67 , 19 67 , to 7/25 , 19 67 , that (I) (we) last saw the deceased alive on 7/25 , 19 67 , and that death occurred at 10:35 PM from causes and on the date stated above.			
22a. SIGNATURE A. Arengo, M. D.		22b. DATE SIGNED 7/26/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-27-67	23c. NAME OF CEMETERY OR CREMATORY RESTHAVEN	23d. LOCATION (City or Town) (County) (State) FREDERICK FRED. MD.
24. FUNERAL DIRECTOR SALAMONE FUNERAL HOME FREDERICK, MD		25a. REC'D BY REGISTRAR JUL 28 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

CERTIFICATE OF DEATH

03830

Name of Deceased		Date of Death		Place of Death	
John Doe		10/15/1918		Washington, D.C.	
Age		Sex		Race	
45		Male		White	
Married		Occupation		Cause of Death	
Yes		Teacher		Pneumonia	
Date of Birth		Date of Burial		Place of Burial	
10/15/1873		10/18/1918		Arlington National Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Name of Physician		Name of Registrar		Name of Coroner	
Dr. J. H. Smith		John Doe		John Doe	
Address		Address		Address	
123 Main St.		456 Main St.		789 Main St.	
City		City		City	
Washington, D.C.		Washington, D.C.		Washington, D.C.	
State		State		State	
D.C.		D.C.		D.C.	
County		County		County	
District of Columbia		District of Columbia		District of Columbia	
Date of Certificate		Date of Certificate		Date of Certificate	
10/18/1918		10/18/1918		10/18/1918	
Signature of Registrar		Signature of Registrar		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Name of Registrar		Name of Registrar		Name of Registrar	
John Doe		John Doe		John Doe	
Address		Address		Address	
123 Main St.		123 Main St.		123 Main St.	
City		City		City	
Washington, D.C.		Washington, D.C.		Washington, D.C.	
State		State		State	
D.C.		D.C.		D.C.	
County		County		County	
District of Columbia		District of Columbia		District of Columbia	

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said Court, at the City of Washington, District of Columbia, this 18th day of October, 1918.

JOHN DOE, Registrar

JOHN DOE, Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09399 CERTIFICATE OF DEATH 09399									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-- Taneytown, Md.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown, Md.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>R.D.# 1-M</u>				
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Franklin</u> Last <u>Harman</u>					4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 6, 1897</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George I. Harman</u>					14. MOTHER'S MAIDEN NAME <u>Nettie N. Kehn</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-3152</u>		17. INFORMANT <u>Mrs. Daniel F. Harman, Taneytown, Md. R.D.# 1</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis Chronic, Tertiary Lues (Treated)</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>6 yrs</u> <u>10+ yrs</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 20, 1963</u> to <u>July 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 14, 1967</u> , and that death occurred at <u>8:10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>E. Ambler Thompson</u> M.D.					22b. DATE SIGNED <u>July 6, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>E. Ambler Thompson</u>					22d. ADDRESS <u>Taneytown, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		23d. LOCATION (City, town or county) (State) <u>Emmitsburg, Frederick Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Clarence E. Wilson</u> ADDRESS <u>Emmitsburg, Md.</u>					25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		

8082

8630

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

09400

CERTIFICATE OF DEATH

09400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 21 mo. 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Oscar Last HAWKINS		4. DATE OF DEATH Month July Day 23 Year 1967	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1902
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME - dec.		14. MOTHER'S MAIDEN NAME Mary - dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 056-16-7041	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration bronchopneumonia, source unknown DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH Days Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Inactive, multiple tuberculous cavities.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-2-67 , 19__, to 7-23-67 , 19__, that (I) (we) last saw the deceased alive on 7-23-67 , 19__, and that death occurred at 1:15 p.m. causes and on the date stated above.			
22a. SIGNATURE Julian Radzykewycz, M.D.		22b. DATE SIGNED 7-23-67	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		25a. REC'D BY REGISTRAR JUL 25 1967	
25b. REGISTRAR'S SIGNATURE James J. J...		DATE	

Form with multiple sections and fields, including a large circular stamp on the right side. The text is mostly illegible due to blurriness and orientation. Visible fragments include:

- Top left: "1. Name of the..."
- Top center: "2. Date of..."
- Top right: "3. Place of..."
- Middle left: "4. Description of..."
- Middle center: "5. Remarks..."
- Middle right: "6. Signature..."
- Bottom left: "7. Date of..."
- Bottom center: "8. Place of..."
- Bottom right: "9. Signature..."

Vertical text on the right margin, likely a page number or reference code, oriented vertically. The text is mostly illegible but appears to be a sequence of numbers and letters.

09401

CERTIFICATE OF DEATH

09401

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. CITY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1930 N. Arlington Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MORIAH Middle NMN Last JACKSON				4. DATE OF DEATH Month 7 Day 11 Year 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1886		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 11 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rawleigh Smith				14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6011		17. INFORMANT Records Address Sykesville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion or Myocardial Infarction DUE TO Senility, generalized Arteriosclerosis DUE TO Encephalomalacia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE DISEASE DISEASE GIVEN IN PART I(g) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-24, 1964 pta 7/11 , 19 67 , that (I) (we) last saw the deceased alive on 7/11 19 67 , and that death occurred at 9:30 M. from causes and on the date stated above.							
22a. SIGNATURE I. Esendal, M.D. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 7/12/67			
22c. PHYSICIAN'S NAME (Type) I. Esendal, M.D., Staff Psychiatrist				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-67		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens St.				25a. REC'D BY REGISTRAR JL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2801

IN THE COURT OF

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09402

CERTIFICATE OF DEATH

09402

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2746 Baker St.	
3. NAME OF DECEASED (Type or print) WILLIAM BLAINE JOHNSON		4. DATE OF DEATH Month July Day 2 Year 19 67	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-93
9. AGE (In years last birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffeur	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Stationary Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Johnson		14. MOTHER'S MAIDEN NAME Mary Louise Bentley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-1923	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Old Infarct; Coronary arteriosclerosis DUE TO (c) Broncho pneumonia		INTERVAL BETWEEN ONSET AND DEATH months years days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. w/cerebral arteriosclerosis w/psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-19- , 19 65 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9 a.m. , from causes and on the date stated above.			
22a. SIGNATURE Ernest Beiser		22b. DATE SIGNED 6/3/67	
22c. PHYSICIAN'S NAME (Type) Herbert E. Natter		22d. ADDRESS Springfield State Hospital, Sykes., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/6/67	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PKY.		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md	
24. FUNERAL DIRECTOR Herbert E. Natter 3035 W. North Ave		25a. REC'D BY REGISTRAR DATE JUL 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

30403

CENTRAL OF ALABAMA

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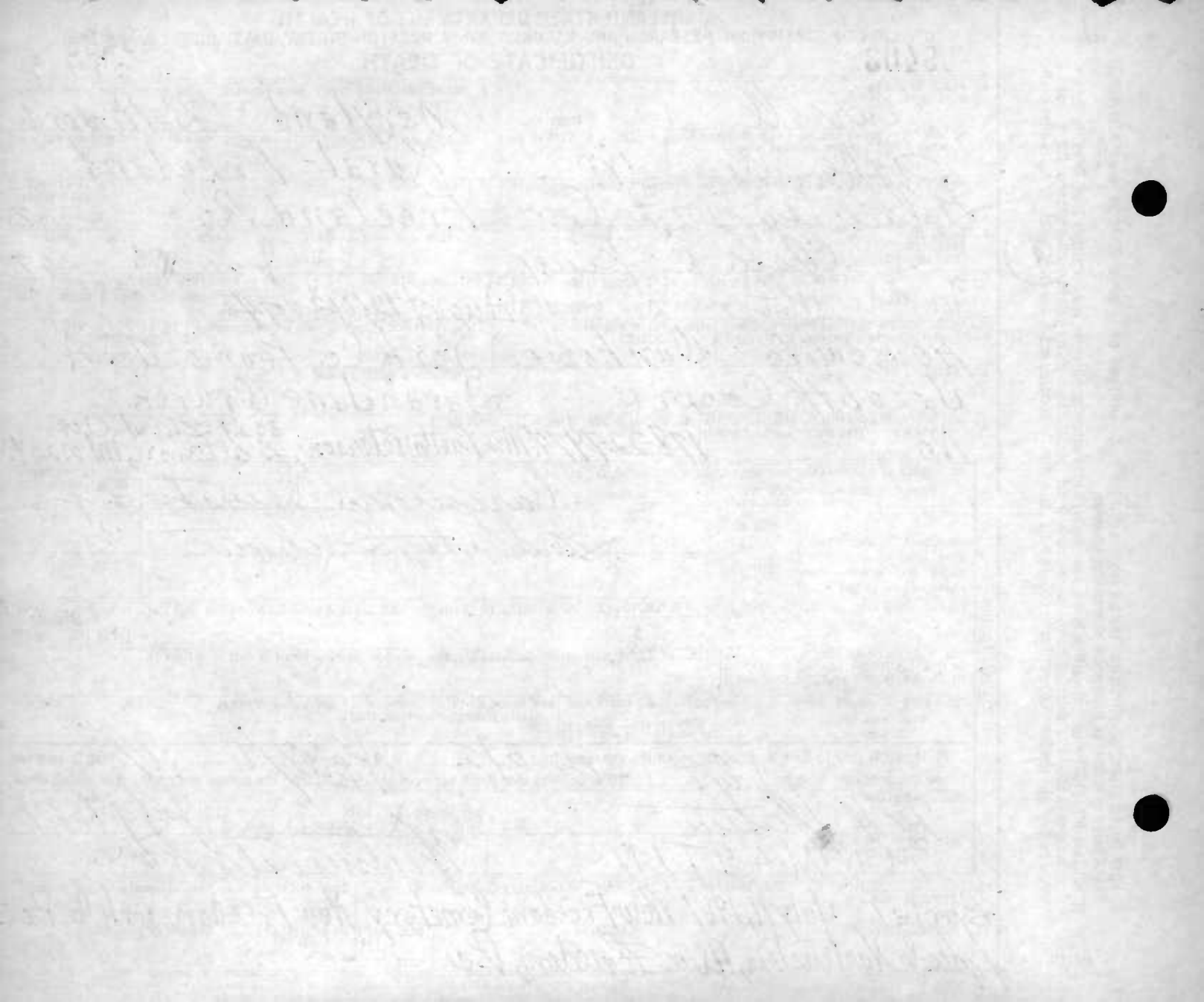
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VR A15 (4)
20M 1/65

09403

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>		d. STREET ADDRESS <u>Freeland Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Chas. C. King</u>		First <u>Chas</u> Middle <u>C</u> Last <u>King</u>		4. DATE OF DEATH <u>July 18</u> 19 <u>67</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 12 1892</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>York Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
13. FATHER'S NAME <u>Jacob H. Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Orwick</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>178-22-7977</u>		17. INFORMANT <u>Mrs. Luetta Peterson, 3021 Third Ave., Baltimore, Md. 21234</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X Carcinoma Breast</u> DUE TO (b) <u>Leukemia</u> DUE TO (c) <u>Schistocytosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>66</u> to <u>7/8</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>July 8</u> , 19 <u>67</u> , and that death occurred at <u>1:45</u> M. from the causes and on the date stated above.															
22a. SIGNATURE <u>M. H. Martin</u>				22b. DATE SIGNED <u>July 8-67</u>				22c. PHYSICIAN'S NAME (Type) <u>M. H. Martin</u>		22d. ADDRESS <u>Freeland Rd.</u>		22e. M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 16, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>New Freedom York Co. Pa.</u>			
24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. DATE			



09404

CERTIFICATE OF DEATH

09404

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 4yrs. 25dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 601 Ponca St., Baltimore d. STREET ADDRESS 601 Ponca St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT (NMN) KOLODZIEJ		4. DATE OF DEATH JULY 14 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-03
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bartholomew Kolodziej		14. MOTHER'S MAIDEN NAME Sofia (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1928-1943		16. SOCIAL SECURITY NO. 214-24-4851	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, left side of neck (lymph node) DUE TO Node Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 161X (b) Squamous cell carcinoma of larynx DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Weeks Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, without qualifying phrase			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-19-63 , 19__, to 7-14-67 , 19__, that (I) (we) last saw the deceased alive on 7-14-67 , 19__, and that death occurred at 6:10 M., from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 7-18-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-19-67	23c. NAME OF CEMETERY OR CREMATORY New Freedom	23d. LOCATION (City or Town) (County) (State) Sykesville Md.
24. FUNERAL DIRECTOR Harry W. Hight		25a. REC'D BY REGISTRAR JUL 20 1967	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4032

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09405											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MAIN ST.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> d. STREET ADDRESS <u>MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM THOMAS KOONTZ</u>						4. DATE OF DEATH Month Day Year <u>JULY 13 1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 22-1888</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MILTON KOONTZ</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE SNOOK</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-36-4026</u>		17. INFORMANT Address <u>MARY KOONTZ UNION BRIDGE MD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1906</u> DUE TO <u>Malignant melanoma, rt thumb</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>1943</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June 1961</u> , 19... to <u>7/13/67</u> , 19..., that (I) (we) last saw the deceased alive on <u>7/11/67</u> , 19..., and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>JH Caricofe</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/13/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JH CARICOFE</u>						22d. ADDRESS <u>UNION BRIDGE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u>				23d. LOCATION (City, town or county) (State) <u>UNION BRIDGE RURAL MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartley & Sons Union Bridge Md</u>						25a. REC'D BY REGISTRAR <u>J Charles Judge</u>		25b. REGISTRAR'S SIGNATURE			
DATE <u>JUL 17 1967</u>											

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ESTIMATE OF DEATH

[Faint, mostly illegible text from a form, possibly containing medical or legal details.]

JUL 1 1985

CERTIFICATE OF DEATH

09406

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 66 York Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Alveta Koutz		4. DATE OF DEATH Month Day Year July 3, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1880
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days 20 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Silver Run, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Bankard		14. MOTHER'S MAIDEN NAME Ellen Smeak	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 15-00-00000	
17. INFORMANT Mrs. Romaine Motter, Taneytown, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteoarthritis Cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/25 , 19 67 , to 7/3 , 19 67 that (I) (was) last saw the deceased alive on 6/30 , 19 67 , and that death occurred at 6:30 M. from causes and on the date stated above.			
22a. SIGNATURE R. S. McVaugh		22b. DATE SIGNED 7/4/67	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		22d. ADDRESS Taneytown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 6, 1967	
23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR John H. Skiles C. O. Fuss & Son		25a. REC'D BY REGISTRAR JUL 7 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100

STATE OF TEXAS

County of _____

City of _____

Know all men by these presents, _____

do hereby certify that _____

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

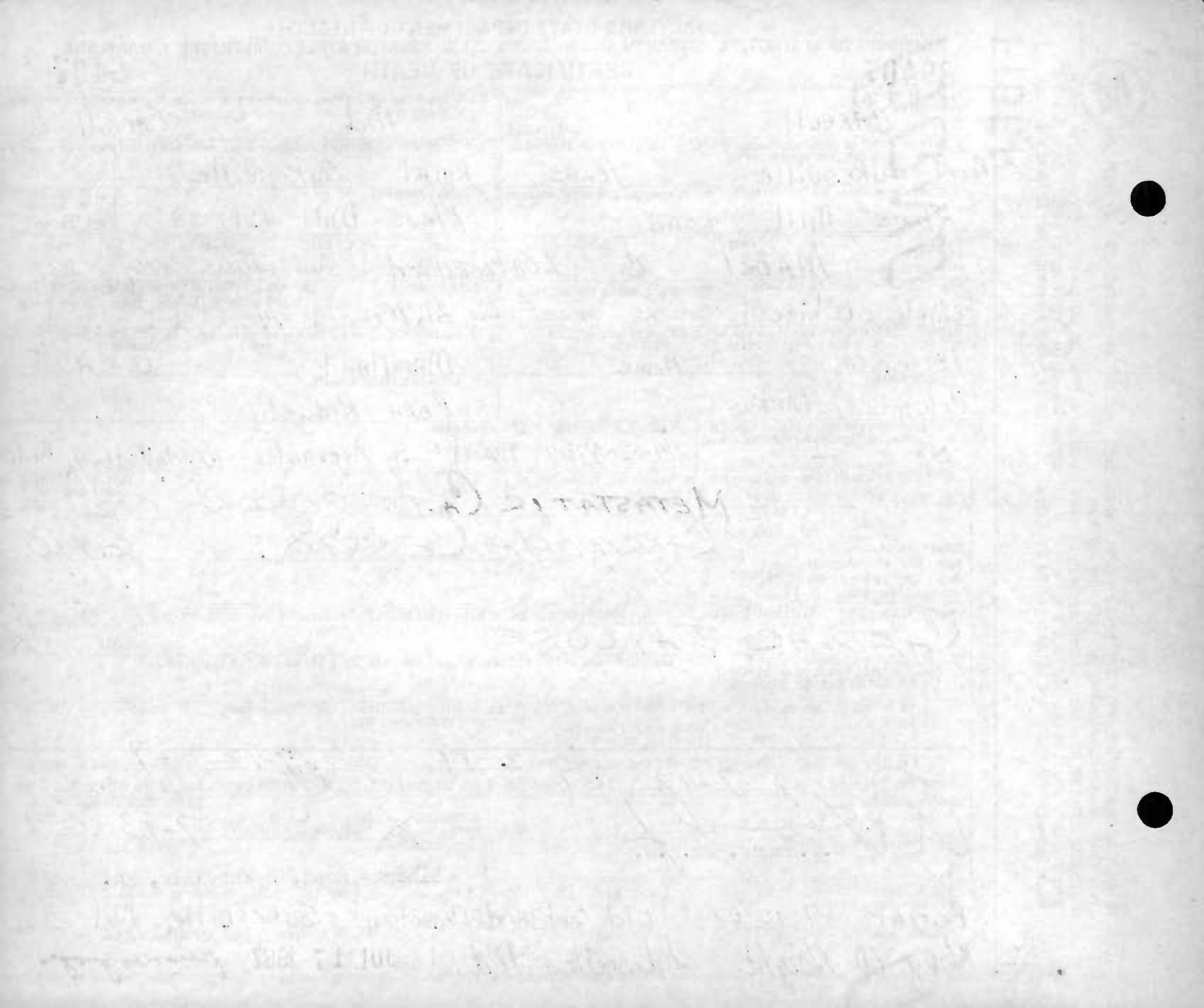
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09407

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sykesville	
c. LENGTH OF STAY IN 1b YEARS		d. STREET ADDRESS Klees Mill Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Klees Mill Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mabel C. Leatherwood		4. DATE OF DEATH Month July Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1892
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Columbus PARKER		14. MOTHER'S MAIDEN NAME CORA Ridgely	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-3727	
17. INFORMANT MR. WM S. Alexander - Randallstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC C. OF COLON. DUE TO (b) CARCINOMA CERVIX. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 MO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIAC FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-19 , 19 66 to 7-12 , 19 67 , that (I) (we) last saw the deceased alive on 7-12 , 19 67 , and that death occurred at 8:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE R.V. Houck, Jr. M.D.		22b. DATE SIGNED 7-13-67	
22c. PHYSICIAN'S NAME (Type) R.V. Houck, Jr. M.D.		22d. ADDRESS Liberty Road, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-15-67	
23c. NAME OF CEMETERY OR CREMATORY old Oakland Cemetery		23d. LOCATION (City, town or county) (State) Sykesville, Md.	
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR JUL 17 1967	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09408

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 4 yr 1 mo 30 da		d. STREET ADDRESS 2728 Georgetown Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle W. Last Loeffelholz		4. DATE OF DEATH Month July Day 15 Year 19 67	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-97
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Loeffelholz		14. MOTHER'S MAIDEN NAME Christina Handel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-54-2699 T	
17. INFORMANT Springfield State Hosp. records		Address Sykesville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Large infected bed sores Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy with mental deficiency		INTERVAL BETWEEN ONSET AND DEATH Weeks Weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-17-26 , 19__, to 7-15-67 , 19__, that (I) (we) last saw the deceased alive on 7-15-67 , 19__, and that death occurred at 9am M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn, M.D.		22b. DATE SIGNED 7-15-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/18/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. REC'D BY REGISTRAR JUL 18 1967	
ADDRESS 4107 Wilkens Ave. 21229		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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CERTIFICATE OF DEATH

09409

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				d. STREET ADDRESS R. D. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marie Katharine Loots		4. DATE OF DEATH Month Day Year July 2, 1967					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1900		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Balto. City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Kinstler				14. MOTHER'S MAIDEN NAME Katharine Ritz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-52-5715		17. INFORMANT Address Mr. Charles A. Loots Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 24, 1967 , to July 2, 1967 that (I) (we) last saw the deceased alive on July 2, 1967 , and that death occurred at 9:40 PM , from causes and on the date stated above.							
22a. SIGNATURE John S. Harshey				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/2/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.				22d. ADDRESS 8 Archer St. Westminster Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead, Md.	
24. FUNERAL DIRECTOR ADDRESS Tipton-Eline Funeral Home Hampstead, Md.				25a. REC'D BY REGISTRAR DATE JUL 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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County

City

Age

Sex

Marital Status

County General Hospital

Age

Sex

Marital Status

Occupation

Education

Death Date, 1900

Place of Death

Cause of Death

Date of Death

Medical History

Previous Illnesses

Physician's Name, Address, and Signature

No.

Remarks

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Burial Officer

Signature of Witness

Signature of Minister

Buried at

Interment

Page 10

Page 10

CERTIFICATE OF DEATH

09410

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN lb 20y. 5m. 12d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Frances Mills		4. DATE OF DEATH Month Day Year 7 7 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/29/98
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telephone operator		11. BIRTHPLACE (County & State, or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jasper Newton Harrison	
14. MOTHER'S MAIDEN NAME Frances B. Burrows		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 220-54-6603		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic acidosis DUE TO (b) Bronchopneumonia DUE TO (c) Chronic brain syndrome with central nervous system syphilis, meningo-encephalitic, with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH hours days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome with central nervous system syphilis, meningo-encephalitic, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 1/25/1947 , to 7/7/1967 , that he (we) last saw the deceased alive on 7/7/1967 , and that death occurred at 3:30 a.m. from causes and on the date stated above.			
22a. SIGNATURE <i>Naci N. Buyukunsal</i>		22b. DATE SIGNED 7/7/67	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-9-67	23c. NAME OF CEMETERY OR CREMATORY Park Height	23d. LOCATION (City or Town) (County) (State) Brunswick Ind. Ind
24. FUNERAL DIRECTOR Flete General Home - Brunswick Md.		25a. REC'D BY REGISTRAR DATE JUL 11 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

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City of _____

State of _____

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD.</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSPITAL.</u>		d. STREET ADDRESS <u>TREVANION ROAD. 06.1</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES DONALD MITTEN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 6, 1919</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POULTRY FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES V. MITTEN</u>		14. MOTHER'S MAIDEN NAME <u>M. IRENE HASENHEIMER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>215-14-2792</u>	
17. INFORMANT <u>WIFE AT #1 UNION</u>		Address <u>BRIDGE, MD.</u> <u>MRS. CHARLES D. MITTEN</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1991</u> DUE TO <u>metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1967</u> , to <u>July 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1967</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>7/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Anchor St. Westminster, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S LUTHERAN</u>	23d. LOCATION (City or Town) (County) (State) <u>UNION TOWN, CARROLL, MD.</u>
24. FUNERAL DIRECTOR <u>James G. Saffell Jr.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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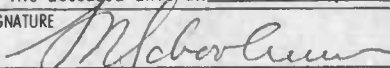
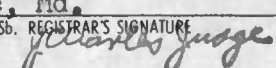
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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY in 1b 17 das. 2 yr. 5 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3312 Hayward Avenue	
3. NAME OF DECEASED (Type or print) First John Middle Malcolm Last MOONEY		4. DATE OF DEATH Month July Day 22 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-4-1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Md. State Roads	9. AGE (In years lost birthday) 63 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Mooney - dec.		14. MOTHER'S MAIDEN NAME Mary E. Kendrick - dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes T/3 1942-1943		16. SOCIAL SECURITY NO. 218-05-9912	
17. INFORMANT Springfield State Hospital Records.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 150X IMMEDIATE CAUSE (a) Squamous cell carcinoma of esophagus. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with alcoholic intoxication with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that A (this hospital) attended the deceased from 2-5-65 , 19____, to 7-22-67 , 19____, that (I) (we) last saw the deceased alive on 7-22-67 , 19____, and that death occurred at 5:30 PM , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 7/22/67	
22c. PHYSICIAN'S NAME (Type) M. Schoolman, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/25/1967	23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR B. K. Korman		25. REC'D BY REGISTRAR JUL 25 1967	
ADDRESS 4611 Park Heights Av. Balto. Md.		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09413

CERTIFICATE OF DEATH

09413

1. PLACE OF DEATH a. COUNTY <u>WILMINGTON</u> <u>DE</u> <u>CARROLL COUNTY</u> <u>MD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> <u>Westminster Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>61 UNION STREET</u>		d. STREET ADDRESS <u>61 Union St</u>	
3. NAME OF DECEASED (Type or print) First <u>Myers</u> Middle <u>Emma</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4, 1891</u>
9. AGE (In years lost birthday) yrs. <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Susan Brady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>1913-12-8223</u>		16. SOCIAL SECURITY NO. <u>213-12-8223</u>	
17. INFORMANT <u>Ella Gibson</u>		Address <u>61 Union St (Forest View)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO <u>Carcinoma left breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma left breast</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cardiac decompensation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>55</u> , to <u>7/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> , 19 <u>67</u> , and that death occurred at <u>3 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Julius Chepko</u>		22b. DATE SIGNED <u>7/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko M.D.</u>		22d. ADDRESS <u>856 W. Green St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arboretum Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>V. Brooks Ruggold</u>		25a. REC'D BY REGISTRAR <u>14637</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 3 1967</u>	

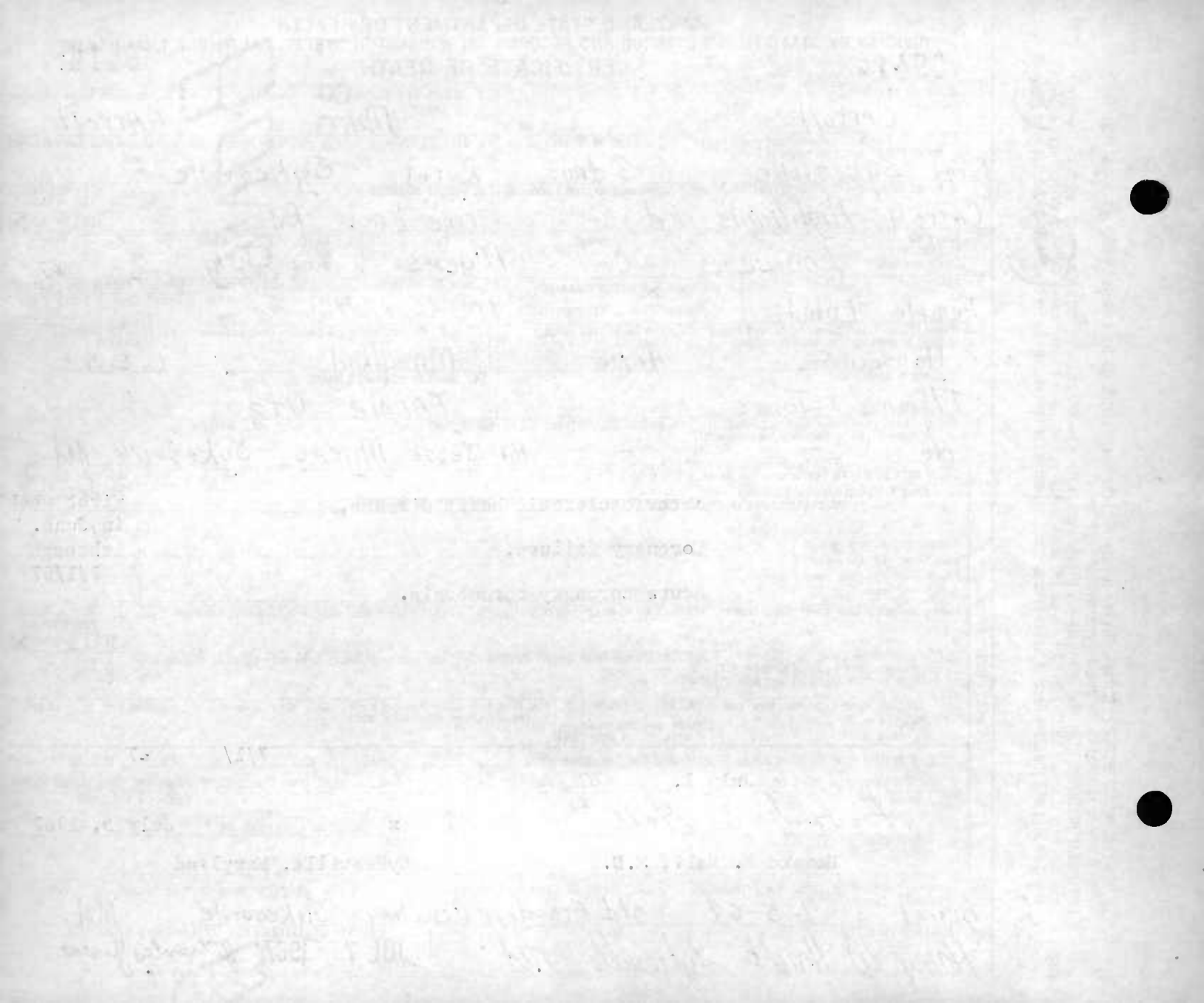
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09414 CERTIFICATE OF DEATH 09414

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>Pine Knob Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Highlands Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise C. Myers</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Utz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. Jesse Myers - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary failure,</u> DUE TO (c) <u>Acute coronary thrombosis.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1st week</u> <u>18 June</u> <u>through</u> <u>7/1/67</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 1,</u> 19 <u>67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>July 5, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Freedom Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

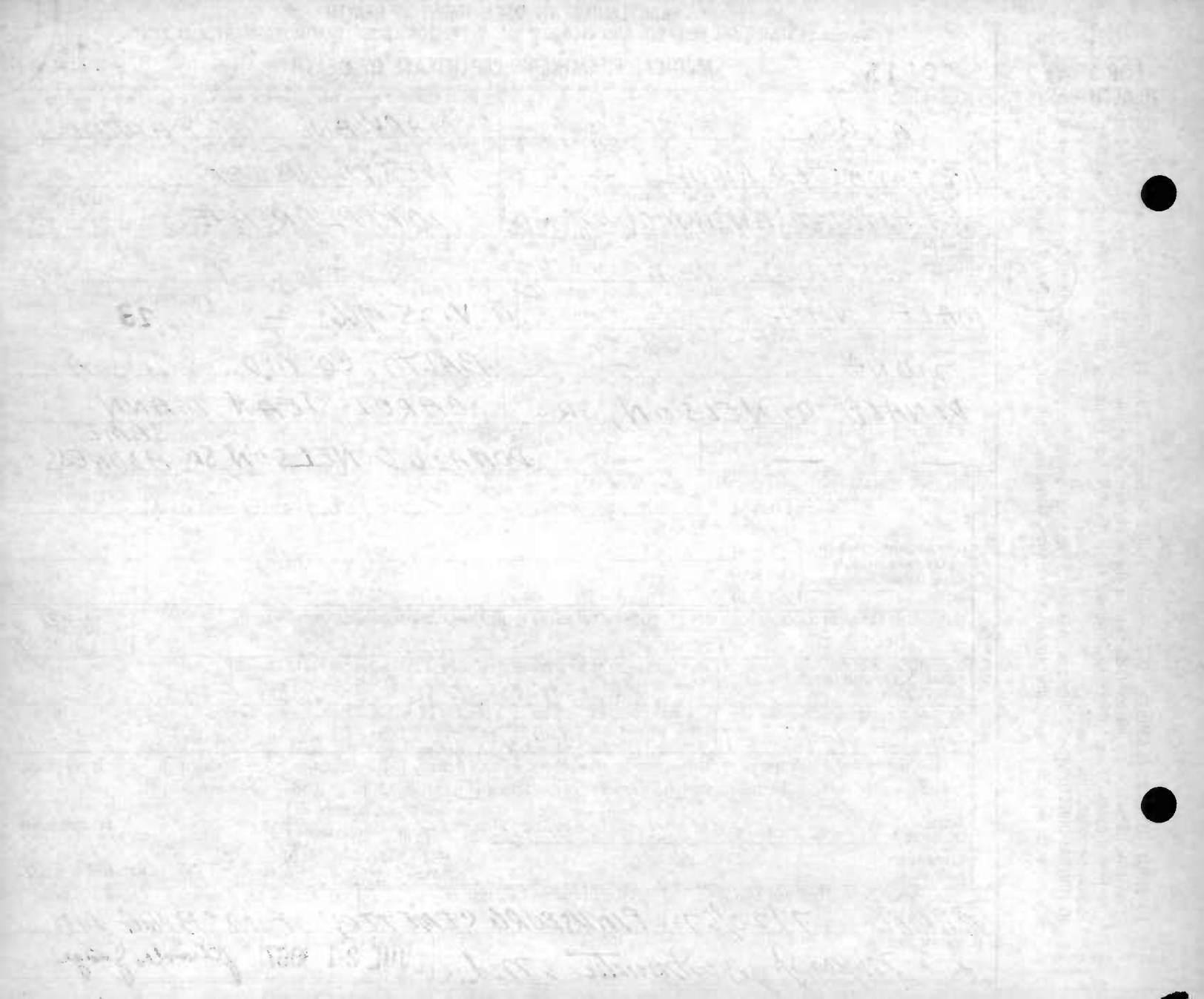
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RURAL</u>		c. LENGTH OF STAY IN lb <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT #140 AT SANDY MOUNT, RD.</u>		d. STREET ADDRESS <u>10 POPLAR AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>DONALD DAVID NELSON JR.</u>		4. DATE OF DEATH <u>7-18-67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 25 1966</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR <u>7</u> Months <u>13</u> Days	
11. BIRTHPLACE (State or foreign country) <u>BALTO. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DONALD D. NELSON, SR.</u>		14. MOTHER'S MAIDEN NAME <u>CAROL JEAN MANN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>DONALD D. NELSON, SR.</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull & Fractured Left Femur</u> DUE TO <u>Left Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>50 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car struck by truck bank on Route 140 U.S. near Sandy Mount</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:45 7-18 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 140 U.S.</u>		20f. (City or town) <u>Westminster</u> (County) <u>Carroll</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>7-18-67</u>	
ACTUAL SIGNATURE <u>W. L. Speichers</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. L. Speichers</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PINKSBURG CEMETERY</u>		23d. LOCATION (City or Town) <u>PINKSBURG MD</u> (County) <u>MD</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>		25a. RECD BY REGISTRAR <u>JUL 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		26. <u>—</u>	



CERTIFICATE OF DEATH

09416

09416

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) THURMONT			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL				d. STREET ADDRESS ROUTE # 1			
3. NAME OF DECEASED (Type or print) First CHARLES Middle MEDWELL Last RAMSBURG				4. DATE OF DEATH Month 7 Day 13 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/1872		9. AGE (In years lost birthday) 94 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer unk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL RAMSBURG				14. MOTHER'S MAIDEN NAME SAVILLA BAUGHTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-20-9360		17. INFORMANT Address SPRINGFIELD STATE HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4321 DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 8 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic Brain Syndrome assoc. with circulatory disorder with psy. react							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/19 , 19 67 , to 7/13 , 19 67 , that (I) (we) last saw the deceased alive on 7/13 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Alberto Arengo</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/13/67	
22c. PHYSICIAN'S NAME (Type) Alberto Arengo, M.D.				22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF July 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Lewisstown		23d. LOCATION (City or town) (County) (State) Lewisstown, Frederick, Md.			
24. FUNERAL DIRECTOR Raymond E. Creeger ADDRESS Raymond E. Creeger, Thurmont, Md.				25a. REC'D BY REGISTRAR DATE JUL 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CERTIFICATE OF DEATH

1918

NAME OF DECEASED

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09417

CERTIFICATE OF DEATH

09417

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, New Windsor			c. LENGTH OF STAY IN lb 1 Month			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Taneytown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hortons Boarding Home				d. STREET ADDRESS Taneytown, Md. R. D. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary Margaret Reaver First Middle Last				4. DATE OF DEATH July 27 19 47 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1890		9. AGE (In years last birthday) yrs. 76	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework, Ret. Her own home.			10b. KIND OF BUSINESS OR INDUSTRY Her own home.		11. BIRTHPLACE (County & State, or foreign country) Adams County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Study				14. MOTHER'S MAIDEN NAME Alberta Rittase			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 179-20-8670		17. INFORMANT 326 W. Myrtle St. Address David M. Reaver Littlestown, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V.D. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/11/67 , 19, to 7/27/67 , 19, that (I) (we) last saw the deceased alive on 7/27/67 , 19, and that death occurred at 9:00 A M, from causes on and on the date stated above.							
22a. SIGNATURE M. E. Robertson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/27/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS New Windsor, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/67		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll Co., Md.	
24. FUNERAL DIRECTOR Richard A. Little				ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

STATE OF NEW YORK

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09418

CERTIFICATE OF DEATH

09418

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b My Airey	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co Hosp		d. STREET ADDRESS Box 115	
3. NAME OF DECEASED (Type or print) Calvin		4. DATE OF DEATH Month July Day 19 Year 19 67	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 17, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ironworker		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	9. AGE (In years last birthday) 78
11. BIRTHPLACE (County & State, or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Amanda Horton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 12, 19 67 , to July 19, 19 67 , that (I) (we) last saw the deceased alive on July 19, 19 67 and that death occurred at 2:45 PM , from causes and on the date stated above.			
22a. SIGNATURE John S. Harshy		22b. DATE SIGNED 7/19/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHY M.D.		22d. ADDRESS Baucher St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/24/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park	23d. LOCATION (City or Town) (County) (State) Balto Co Md
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave		25a. REC'D BY REGISTRAR JUL 21 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

RECEIVED

1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <div>09419</div> <div>Item #3 Film #G390 7/26/67</div> <div>Item 8 Film #G390 7/26/67</div> </div> <div style="text-align: center;"> <div>09419</div> <div>Item #3 Film #G390 7/26/67</div> <div>Item 8 Film #G390 7/26/67</div> </div>									
<div style="text-align: center;"> <div>09419</div> <div>Item #3 Film #G390 7/26/67</div> <div>Item 8 Film #G390 7/26/67</div> </div> <div style="text-align: center;"> <div>09419</div> <div>Item #3 Film #G390 7/26/67</div> <div>Item 8 Film #G390 7/26/67</div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home Inc.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u> d. STREET ADDRESS <u>R D # 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rzeszutek</u> Last <u>Rzeszutka</u>					4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1914</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chicopee, Mass.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Kusiak</u>					14. MOTHER'S MAIDEN NAME <u>Mary Musiak</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Judy Shivers, RDI Box 394A Hampstead, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>343X Pneumonia (Lobar)</u> (b) <u>Atrophy of brain</u> (c) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 mo</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>January 1967</u> to <u>7/17</u> 1967 , that (I) (we) last saw the deceased alive on <u>7/14</u> 1967 , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>D. A. Knight M.D.</u>					22b. DATE SIGNED <u>7/19/67</u>		22c. PHYSICIAN'S NAME (Type) <u>D. A. KNIGHT M.D.</u>		
22d. ADDRESS <u>21074</u>					22e. ADDRESS <u>Chicopee, Mass.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FAIR</u>		23d. LOCATION (City, town or county) (State) <u>Chicopee, Mass.</u>		
24. FUNERAL DIRECTOR <u>John E. Goff</u>					24a. REC'D BY REGISTRAR <u>Charles Young</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Young</u>		

Cornell

Manchester

Long View Nursing Home, N.Y.

May

Female white

Hospital

John Kusick

No

Examination (later)
History of tumor
Biopsy

April 24

Chicago, Mass

July 17

Resection

R.D. #1

3 weeks Rest -

Mayland

Cornell

June 22 1950

Examination, mid

Dr. Wright M.D.

CERTIFICATE OF DEATH

09420

09420

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSP.</u>		d. STREET ADDRESS <u>RT. 140</u>	
3. NAME OF DECEASED (Type or print) <u>PAUL RANDOLPH SHAFFER</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 9, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>61</u>
11. BIRTHPLACE (County & State, or foreign country) <u>NEW MARKET VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL W. SHAFFER</u>		14. MOTHER'S MAIDEN NAME <u>MARY CAROLINE NEWLAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-01-1757</u>	
17. INFORMANT <u>HAROLD L. SHAFFER, WESTMINSTER, MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1967</u> , to <u>July 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 4, 1967</u> , and that death occurred at <u>3:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harsney</u>		22b. DATE SIGNED <u>7/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSNEY, M.D.</u>		22d. ADDRESS <u>8 Archer St. Westminster, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH</u>	23d. LOCATION (City or Town) (County) (State) <u>RURAL WESTMINSTER MD</u>
24. FUNERAL DIRECTOR <u>J. S. Smyer, Jr., Westminster, Md.</u>		25a. RECEIVED BY REGISTRAR <u>JUL 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CARROLL CO. CENTRAL HALL
 WESTMINSTER 3 WEEKS
 CARROLL CO. CENTRAL HALL
 JULY 4 - 17
 PAUL R. SHAFER
 MADE WHITE
 CARPENTER
 DANIEL W. SHAFER
 MARY CAROLINE SHAFER
 NEW MARKET VA. 11 10
 1876 1902 61
 CARROLL CO. CENTRAL HALL
 WESTMINSTER 3 WEEKS
 CARROLL CO. CENTRAL HALL
 JULY 4 - 17
 PAUL R. SHAFER
 MADE WHITE
 CARPENTER
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CARROLL CO. CENTRAL HALL
 WESTMINSTER 3 WEEKS
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 JULY 4 - 17
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 CARPENTER
 DANIEL W. SHAFER
 MARY CAROLINE SHAFER
 NEW MARKET VA. 11 10
 1876 1902 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09421

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RT#4 c. LENGTH OF STAY IN b. 77 yrs.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RT#4			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) TANNERY ROAD				d. STREET ADDRESS TANNERY ROAD			
3. NAME OF DECEASED (Type or print) First Middle Last BERTIE ELIZABETH SIES				4. DATE OF DEATH Month Day Year JULY 19 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 10, 1890	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) CARROLL CO, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM LOWE				14. MOTHER'S MAIDEN NAME EMMA SHARRER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -		17. INFORMANT Address SAME CHARLES E. SIES, ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure 4201 DUE TO (b) Myocardial ischemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - INTERVAL BETWEEN ONSET AND DEATH 1 hour							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/16 , 19 67 to 7/19 , 19 67 , that (I) (we) last saw the deceased alive on 7/16 , 19 67 and that death occurred at 7 p.m. from the causes and on the date stated above.							
22a. SIGNATURE William R. O'Rourke M.D.				22b. DATE SIGNED 7/20/67			
22c. PHYSICIAN'S NAME (Type) William R. O'Rourke				22d. ADDRESS 150 W. Main St Westminster Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/22/67		23c. NAME OF CEMETERY OR CREMATORY LEISTERS CEMETERY		23d. LOCATION (City, town or county) (State) WESTMINSTER RT#4 Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. Westminster, Md				25a. REC'D BY REGISTRAR J. Charles Judge 25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1901

RECEIVED

JUL 19 1901

U. S. DEPT. OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

1901

RECEIVED

JUL 19 1901

U. S. DEPT. OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

1901

RECEIVED

JUL 19 1901

U. S. DEPT. OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY,
WASHINGTON, D. C.
FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY,
WASHINGTON, D. C.
SUBJECT: [Illegible]
[Illegible text follows]

JUL 19 1901

09422

CERTIFICATE OF DEATH

09422

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 4yr 3mo 6da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 14210 London Lane	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Agnes Last Simms		4. DATE OF DEATH Month July Day 4 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-84
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 15 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Hart		14. MOTHER'S MAIDEN NAME Mary Hart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 205-01-7001	
17. INFORMANT Springfield Hospital REcord		Address Sykesville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease with diffuse DUE TO (c) left ventricle fibrosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-28-63 , 19__, to 7-4-67 , 19__, that (I) (we) last saw the deceased alive on 7-4-67 , 19__, and that death occurred at 2:10AM from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Antonius Glahn</i>		22b. DATE SIGNED 7-4-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 7-7-67	
23c. NAME OF CEMETERY OR CREMATORY Braddock Catholic		23d. LOCATION (City or Town) (County) (State) Braddock Pa.	
24. FUNERAL DIRECTOR Robert A Pumphrey		25a. REC'D BY REGISTRAR JUL 1 1967	
25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			

1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

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— *John R. Meyer, President, American Society of Human Resources*

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09423 CERTIFICATE OF DEATH 09423

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hampstead		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Houcksville Road		d. STREET ADDRESS Houcksville Road	
3. NAME OF DECEASED (Type or print) First Paul Middle Raymon Last Simms		4. DATE OF DEATH Month July Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1905
9. AGE (In years last birthday) 62 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Black & Decker Company		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) Baltimore City		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME John J. Simms		15. MOTHER'S MAIDEN NAME Lillie R. Torbit	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 212-10-9630	
18. INFORMANT Mrs. Dorothy B. Simms		Address Hampstead, Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Brain 1621 DUE TO (b) Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Hepatitis.		INTERVAL BETWEEN ONSET AND DEATH 5mo 8-9mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 64 , to 7-4 , 19 67 , that (I) (we) last saw the deceased alive on 7-2 , 19 67 , and that death occurred at 2:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Maurice C. Porterfield		22b. DATE SIGNED 7-5-67	
22c. PHYSICIAN'S NAME (Type) M.C. Porterfield		22d. ADDRESS Hampstead, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery		23d. LOCATION (City, town or county) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR Tipton-Eline Funeral Home		25a. REC'D BY REGISTRAR JUL 7 1967	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

09424

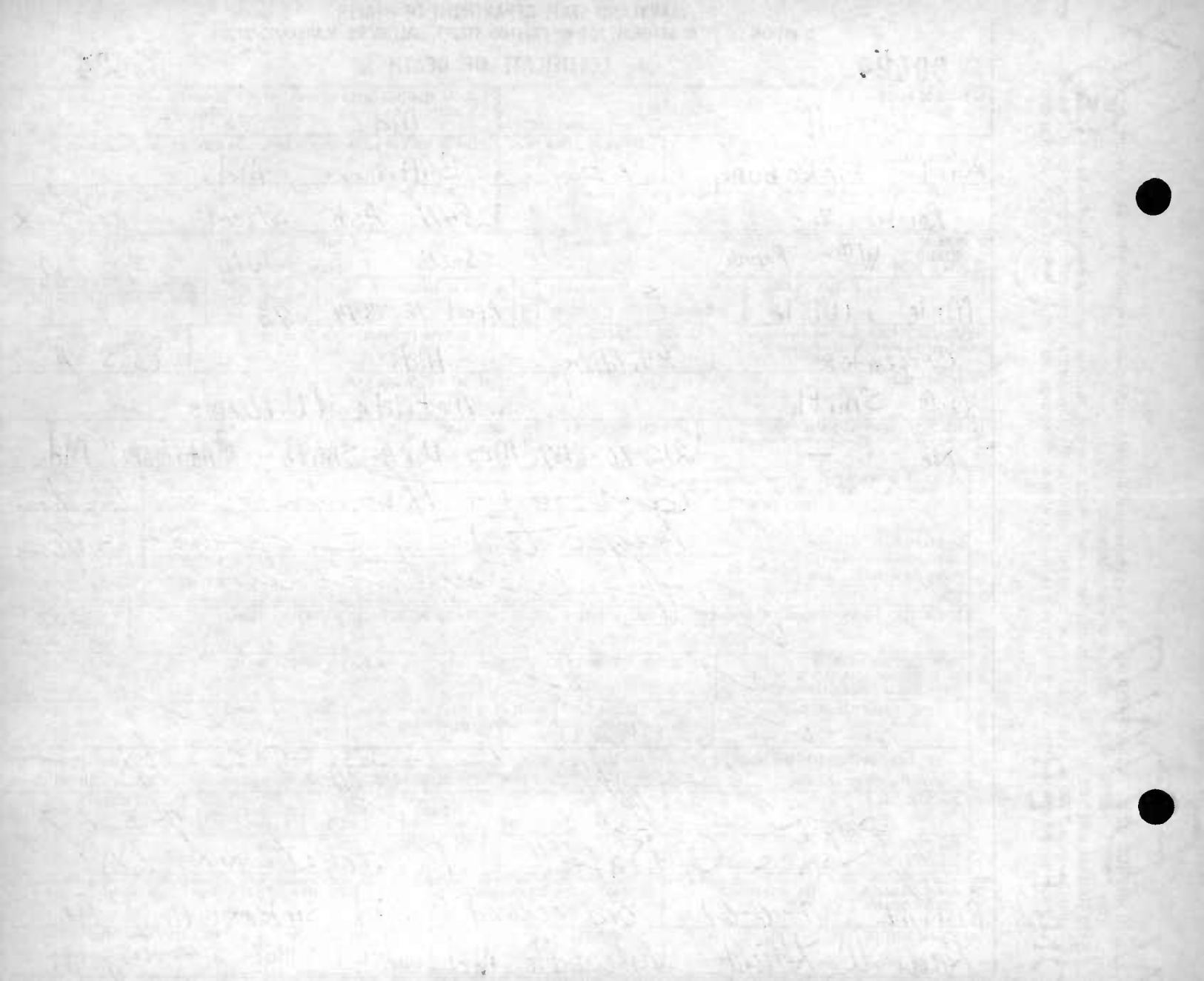
CERTIFICATE OF DEATH

09424

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md.	
c. LENGTH OF STAY in lb 1 DAY		d. STREET ADDRESS 3411 Ash Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wm Frank First Middle Last		4. DATE OF DEATH July 3, 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1894
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm Smith		14. MOTHER'S MAIDEN NAME Matilda Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-8137	
17. INFORMANT Mrs. Dora Smith - Baltimore, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Hypertension - cardio- DUE TO (c) vascular arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Two hours 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1-1930 to 7-2-1967 that (I) was last saw the deceased alive on 6-24-1967 , and that death occurred at 11P M, from causes on and on the date stated above.			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 7-3-67	
22c. PHYSICIAN'S NAME (Type) James G. Saffell		22d. ADDRESS Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-6-67	
23c. NAME OF CEMETERY OR CREMATORY Old Oakland Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville, Md.	
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR JUL 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



09425

CERTIFICATE OF DEATH

09425

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 11 mos. 1 dy. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 920 Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM ROY SMITH		4. DATE OF DEATH Month JULY Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1889
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morgan Smith		14. MOTHER'S MAIDEN NAME Martha Cavandar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-36-9062	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease, with psychotic reaction. Infected bedsores.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-25-66 , 19 67 , to 7-26-67 , 19 67 , that (I) (we) lost saw the deceased alive on 7-26-67 , 19 67 , and that death occurred on 7-26-67 , 19 67 , from causes and on the date stated above.			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED 7-26-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		23d. LOCATION (City or Town) (County) (State) ARTEMAS, PA.	
24. FUNERAL DIRECTOR <i>Right Funeral Home</i> <i>Donald Kiley</i>		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8200

DEPARTMENT OF STATE

10

TO THE SECRETARY OF STATE

FROM THE SECRETARY OF STATE

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

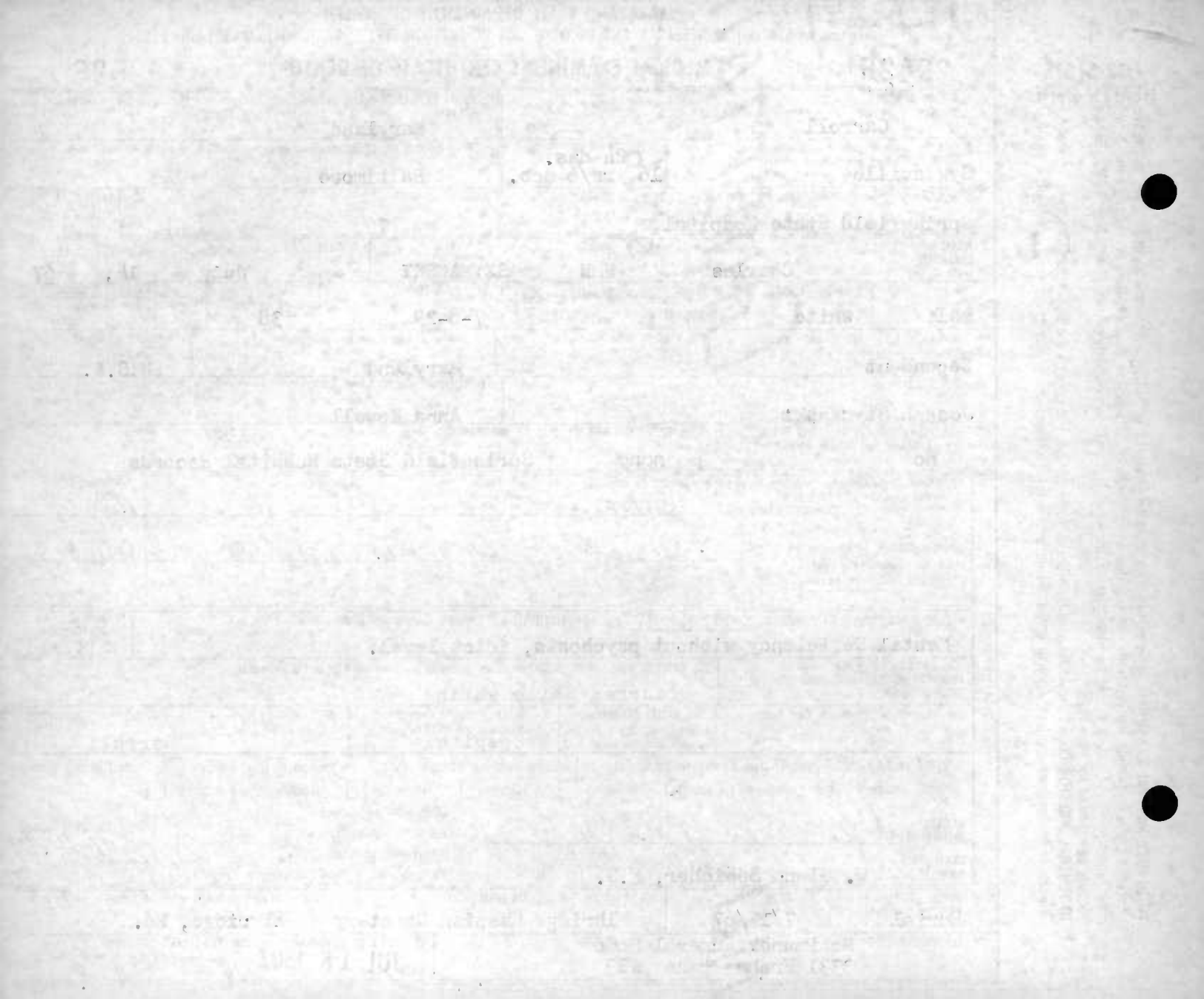
VR A15ME (5)
6M 1/66

09426

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09426

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 24 das. 16 yrs/6 mos.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS ?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle NMN Last SZYMAWSKI				4. DATE OF DEATH Month July Day 11 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-29		9. AGE (In years lost birthday) 38 yrs.	IF UNDER 1 YEAR Months 11 Days 11	IF UNDER 24 HRS Hours 11 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Szymanski				14. MOTHER'S MAIDEN NAME Anna Kowell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield State Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO (b) Occlusion of Larynx, Trachea & Pharynx DUE TO (c) 921.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH Minutes minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency without psychosis, idiot level.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occurred while eating				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Carroll
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 7-14-67
ACTUAL SIGNATURE W. Glenn Speicher			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/17/67		23c. NAME OF CEMETERY OR CREMATORY Elkridge Russian Cemetery		23d. LOCATION (City or Town) (County) (State) Elkridge, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13				25a. REC'D BY REGISTRAR JUL 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



09427

CERTIFICATE OF DEATH

09427

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>				c. LENGTH OF STAY IN lb <u>YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) <u>ROBERT LEE TIGHE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 9-1930</u>	9. AGE (In years lost birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE PAINTER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>DORSEY TIGHE</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA GRUBB</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>232-32-9425</u>	17. INFORMANT <u>CHARLOTTE TIGHE</u> Address <u>MD UNION BRIDGE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>4201</u> (c) <u>sudden</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/67</u> , 19 <u>67</u> , to <u>7/7/67</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>7/1/67</u> , 19 <u>67</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>M. E. Robertson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>				22d. ADDRESS <u>New Windsor, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JULY 9-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		23d. LOCATION (City or Town) (County) (State) <u>UNION BRIDGE MD</u>			
24. FUNERAL DIRECTOR <u>DD Hutzler & Sons Union Bridge Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

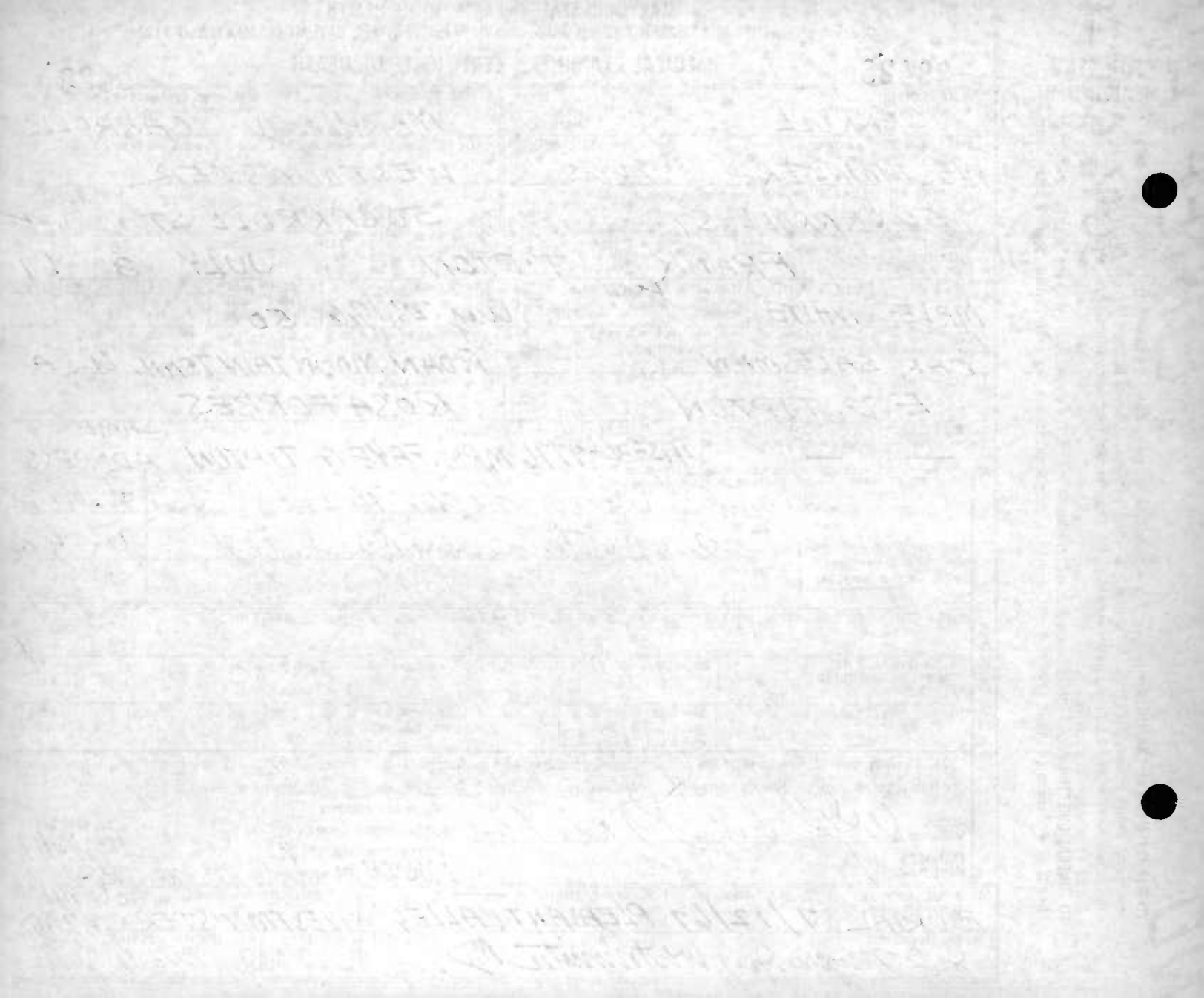
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
c. LENGTH OF STAY IN Tb <u>20 YRS</u>		d. STREET ADDRESS <u>50 CARROLL ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>50 CARROLL ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK TIPTON</u>		4. DATE OF DEATH <u>JULY 8 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1916</u> 50 YRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ROAN MOUNTAIN TENN. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>E.D. TIPTON</u>		14. MOTHER'S MAIDEN NAME <u>ROSA FORBES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>415-36-7776</u>	
17. INFORMANT <u>MRS. FAYE G. TIPTON</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>444 X</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & Diabetes</u> DUE TO <u>4-5460</u> (c)		INTERVAL BETWEEN DEATH AND REPORT <u>4-5460</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William Speikes</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William Speikes</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>7-8-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VALLEY</u>		23d. LOCATION (City or Town) <u>WESTMINSTER RT#7 MD.</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, MD.</u>		25. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
26. DATE <u>JUL 12 1967</u>		27. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marchesville</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carleton</u>			13-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Hospital</u>					d. STREET ADDRESS <u>Porter Bay Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eddie</u> Middle <u>Bearah</u> Last <u>Wilhelm</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Dec 21, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs. Months <u>8</u> Days <u>12</u> Hours <u>1</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore County Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Blundell</u>		14. MOTHER'S MAIDEN NAME <u>Martha Boring</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-48-7520</u>	
17. INFORMANT <u>Mrs William F. Whiles</u>		Address <u>Hampstead Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>Parkinsonism Secondary</u>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov 18, 1965</u> to <u>July 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1967</u> , and that death occurred at <u>1:52 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>July 13, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		23d. LOCATION (City, town or county) (State) <u>Carleton, Md.</u>		24. FUNERAL DIRECTOR <u>John E. Goff - Hampstead Md</u>	
25a. REC'D BY REGISTRAR <u>JUL 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>21074</u>		25d. DATE <u>JUL 18 1967</u>		25e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

1913

W.
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1913 JUL 18

09430

CERTIFICATE OF DEATH

09430

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>18 S. Main Street</i>			d. STREET ADDRESS <i>18 S. Main</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Millad</i> Last <i>WISNER</i>			4. DATE OF DEATH Month <i>July</i> Day <i>22</i> Year <i>1967</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 23, 1889</i>		9. AGE (In years last birthday) yrs. <i>78</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Carroll Co. Md.</i>	
13. FATHER'S NAME <i>Samuel Wisner</i>			14. MOTHER'S MAIDEN NAME <i>Annie Blizzard</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-05-6222</i>		17. INFORMANT <i>Mrs. Treva R. Wisner</i> Address <i>Hampstead, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 17, 1967</i> to <i>July 22, 1967</i> , that (I) (we) lost saw the deceased alive on <i>July 21, 1967</i> , and that death occurred at <i>7:25 a.m.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>Muriel C. Porterfield</i> M.D.		22b. DATE SIGNED <i>7-22-67</i>		22c. PHYSICIAN'S NAME (Type) <i>M.C. Porterfield, M.D.</i>	
22d. ADDRESS <i>Hampstead, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 25, 67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hampstead Cemetery</i>	
23d. LOCATION (City or Town) <i>Hampstead, Md.</i>		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR <i>Tipton-Eline Funeral Home</i>		24a. ADDRESS <i>Hampstead, Md.</i>		24b. REC'D BY REGISTRAR <i>JUL 25 1967</i>	
24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

159

• 2005-2006

0550-7091/98/0005-0000\$05.00/0

FOR STATE HEALTH DEPT.

09431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09431

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Westminister Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminister Gen. Hospital</u>		d. STREET ADDRESS <u>4612 Reisterstown</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First Middle Last <u>WRIGHT</u>		4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1912</u> 9. AGE (In years (by birthday) yrs. <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Peartye Wright</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA ROVERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-16-9031</u>	
		17. INFORMANT Address <u>Dr. Donald Hughes,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull & crushed chest</u> 9121 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Driving tractor, stepped back & it flipped backwards on him</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7-20</u> p.m. <u>1967</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>FARM</u>	20f. (City or town) <u>RO Westminister Md</u> (County) <u>Carroll</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. L. Peacher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. L. Peacher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER, <input checked="" type="checkbox"/> <u>Charles R. Law</u> Address (Street, R.F.D., or County) <u>Westminister Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	23d. LOCATION (City or Town) <u>Baltimore, Maryland</u> (County) <u>Maryland</u> (State)
24. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CONFIDENTIAL

24

11-1-1912

X

Colonel

General

U.S.A.

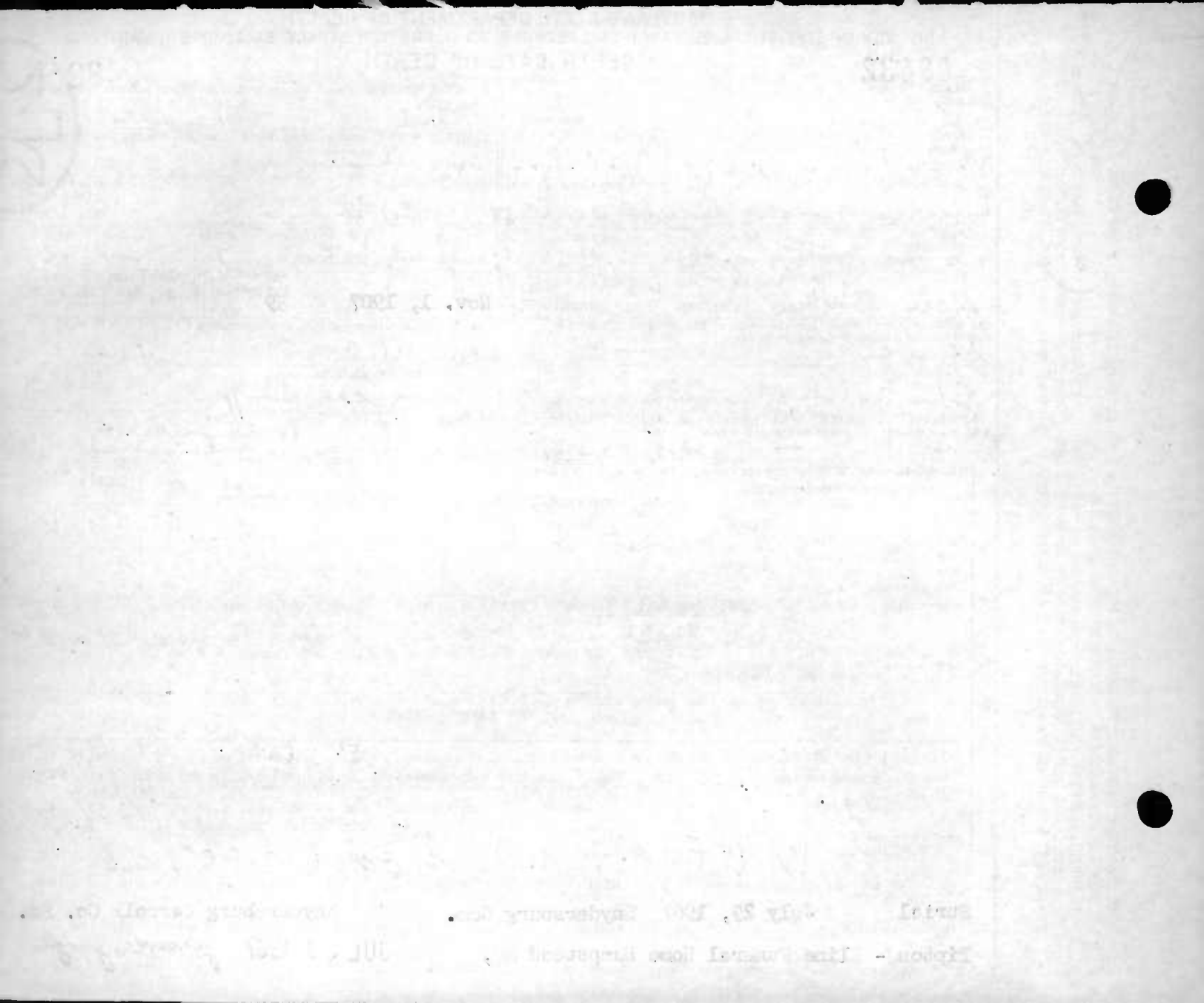
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardbox papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09432		09432	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, md.</u>	
c. LENGTH OF STAY in 1b <u>12 days</u>		d. STREET ADDRESS <u>Longview Nursing Home 1280 Main St. York St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 1280 Main St. York St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Russell</u>		4. DATE OF DEATH <u>7</u> <u>26</u> <u>1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1907</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Yingling</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Shaper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-03-587</u>	
17. INFORMANT <u>Mrs. Lenge Hager</u>		Address <u>18 Charmel Drive, Manchester, md. (daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with</u> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>metastasis to acetabulum & brain</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MON</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus 2) Coronary Artery Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , to <u>July 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> <u>1967</u> , and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Foard</u>		22b. DATE SIGNED <u>7/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard MD</u>		22d. ADDRESS <u>Manchester, md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 29, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Snydersburg Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Snydersburg Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) UNION MILLS c. LENGTH OF STAY IN 1b 1 MO. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEADOW VIEW CONSU. HOME						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 180 W. MAIN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HARRY Middle MILTON Last YOUNG			4. DATE OF DEATH Month JULY Day 29 Year 1967			5. SEX MALE			6. COLOR OR RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH AUG. 30, 1887			9. AGE (In years last birthday) 79 yrs.			10. FUNDER 1 YEAR <input type="checkbox"/> FUNDER 24 HRS. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER, ALSO MARKET EMPLOYEE				10b. KIND OF BUSINESS OR INDUSTRY CARROLL CO. MD				11. BIRTHPLACE (County & State, or foreign country) U.S.A.			
13. FATHER'S NAME JACOB DANIEL YOUNG						14. MOTHER'S MAIDEN NAME LAURA FORMWALT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 216-22-8243A				17. INFORMANT RALPH M. YOUNG Address W. MAIN ST. WESTMINSTER MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 177X DUE TO (c) about 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (Biopsy etc. had been performed)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from about 7-1, 1965, to 7-29, 1967 , that (I) (we) last saw the deceased alive on 7-29 1967 , and that death occurred at 5 P.M. from the causes and on the date stated above.											
22a. SIGNATURE C.H. Billingslea M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED 7-31-67											
22c. PHYSICIAN'S NAME (Type) C.H. Billingslea 22d. ADDRESS Westminster, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL											
23b. DATE THEREOF 8/1/67											
23c. NAME OF CEMETERY OR CREMATORY RIDERS CEMETERY RURAL WESTMINSTER											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR J.S. Myers, Jr., Westminster, Md.											
25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE MD											
DATE AUG 2 1967											

24 hours after death. The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> c. LENGTH OF STAY IN 1b <u>MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROOKFIELD MANOR NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC</u> d. STREET ADDRESS <u>2500 WISCONSIN AVE N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>VIOLET FRANCES YOUNKIN</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1967</u>																			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 7-1883</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MISSOURI</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>DR — DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN BUTLER</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>427-36-4868</u>				17. INFORMANT <u>K E YOUNKIN</u> Address <u>FREDERICK MD</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized atherosclerosis</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. } (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>2/11/67</u> , 19 <u>—</u> , to <u>7/13/67</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>7/13/67</u> , 19 <u>—</u> , and that death occurred at <u>3:15 P.</u> M., from the causes and on the date stated above.																							
22a. SIGNATURE <u>J H CARICOFÉ</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>7/13/67</u>															
22c. PHYSICIAN'S NAME (Type) <u>J H CARICOFÉ</u>				22d. ADDRESS <u>UNION BRIDGE MD</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7/17/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>				23d. LOCATION (City, town or county) (State) <u>SUITLAND MD</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>D D Hartzler & Sons</u>				ADDRESS <u>Union Bridge</u>				25a. REC'D BY REGISTRAR <u>JUL 17 1967</u>				25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23a,b,c & d Film #G390 7/11/67 pc

09435

CERTIFICATE OF DEATH

09435

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN lb 25y. 8m. 10d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1506 N. Collington Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Mary -- Ziegler		4. DATE OF DEATH Month Day Year 7 2 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/91
9. AGE (In years lost birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) silk mill worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ludwig Lindemann		14. MOTHER'S MAIDEN NAME Mary Schaefer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-54-6253	
17. INFORMANT T Springfield Hospital records,		Address Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Chronic hypochromic anemia DUE TO (c) Schizophrenic reaction, catatonic type.		INTERVAL BETWEEN ONSET AND DEATH days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Schizophrenic reaction, catatonic type.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/22/1941 , to 7/2/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/2/1967 , and that death occurred at 12:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal, M. D.		22b. DATE SIGNED 7/2/67	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/4/67	
23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Carroll Md.	
24. FUNERAL DIRECTOR Nancy Haight		25a. REC'D BY REGISTRAR JUL 6 1967	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles J. J...	

